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SHAKUR YOUNG, DIN: 17R3045
GREENE CORRECTIONAL FACILITY
PO BOX 975
COXSACKIE, NY 12051-0975

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
500 PEARL STREET
NEW YORK, NY 10007
HON. JUDGE B. MOSES

RE: SHAKUR YOUNG V. CITY OF NEW YORK, et al. 18-CV-03316

Judge Moses,

I am writing you because I want to submit a copy of the medical release forms that Mr. Nakul Shah has requested. The reason I'm sending you a copy is because I don't want Mr. Shah, to say again that he didn't receive it. Mr. Shah, and your copy of these forms was sent out on the same day.

Also Judge Moses, Mr. Shah had mentioned that his office sent out four request for these forms to be noterized and returned to his office during our phone conference, and I mentioned that only three of these forms was sent out. I highlighted the date of the last set forms that was sent to me which was right before the telephone conference. I recently returned from a court trip. I was taken to Rikers Island RNDC facility and stay there about one week. I had the medical release forms noterized there in the RNDC facility law library. and I mailed them out on Monday 02/04/19.

Again i just wanted to inform the court that Mr. Shah, should be in possession of these forms and cannot claim that he didn't receive them.

Dated: 02/02/19

RESPECTFULLY SUBMITTED,

SHAKUR YOUNG

CC: NAKUL SHAH
The City of New York Law Dept
100 CHURCH STREET
NEW YORK, NY 10007

ZACHARY W. CARTER
Corporation Counsel

The City of New York
LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N.Y. 10007

Fax: 212-356-3509

January 7, 2019

Shakur Young DIN# (17R3045)
Plaintiff PRO SE
Greene Correctional Facility
165 Plank Road
Coxsackie, NY 12051

3RD NOTICE

Re: Shakur Young v. City of New York, et al.
18-CV-03316

Dear Mr. Young:

On November 27, 2018, this office forwarded to your attention a medical release form so that the medical records pertaining to your alleged injuries could be accessed. To date, we have received neither a signed medical release nor a response to our previous letter.

As you have been informed, until the executed release is received by this office, we cannot secure the relevant documents. Consequently, we continue to be unable to properly assess this case, or to proceed to discovery. Your failure to promptly return this release is delaying this litigation. Unless the executed release is returned to this office within seven days of the date of this letter, we will make application to the Court for an order compelling the production of the executed release.

Thank you in advance for your prompt attention to this matter.

Very truly yours,

A.P.
Paralegal
Special Federal Litigation Division

Enc.
cc: Nakul Shah
Assistant Corporation Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

Shakur Young,

Plaintiff,

-against-

City of New York, et al.,

Defendants.

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

18-CV-03316 (VEC) (BM)

TO: HHC; Correctional Health Services 55 Water Street New York, NY 10041
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of SHAKUR YOUNG'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of SHAKUR YOUNG (Date of Birth: [redacted] SS #: [redacted] who was examined or treated in your hospital or by you on or about 8/17/17.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this authorization will expire on the following date, event or condition: April 1, 2019. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
01/24/19, 2018

SHAKUR YOUNG

STATE OF NEW YORK)
: SS:
COUNTY OF Bronx)

On the 24 day of January, 2018, before me personally came and appeared SHAKUR YOUNG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

NOTARY PUBLIC

ADJANIE CRUZ
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01CR6382139
Qualified In Bronx County
Commission Expires October 22, 2022

HHC

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
SHAKUR YOUNG 1694 Madison Aveue., #12E New York, NY 10029	[redacted]	[redacted]
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED:
HHC; Correctional Health Services Medical Records Unit 55 Water Street 18th Floor New York, NY 10041	Information Requested Medical Records Treatment Dates from 9/17 to 12/1/17
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.**
NYC Law Department 100 Church Street New York, NY 10007	☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)
☒ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	☐ Event:_____ ☒ On this date: April 1,2019

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE 01/17/2019	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

OCA Official Form No.: 9(

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
SHAKUR YOUNG	[redacted]	[redacted]
Patient Address		
1694 Madison Avenue., #12E. New York, NY 10029		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
HHC; Correctional Health Services 55 Water Street 18th Floor New York, NY 10041

8. Name and address of person(s) or category of person to whom this information will be sent:
NYC Law Department 100 Church Street New York, NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 09/17 to (insert date) 11/30/17

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	April 1, 2019
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 01/17/2019

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.